LEVEL I IDENTIFICATION SCREEN FOR MENTAL ILLNESS/MENTAL RETARDATION

Instructions for completing this form are on reverse side of this page. WEB Page www.cdhs.ctate.co.us/ohr/mhs/index.html.

Client Name: _____ Social Security Number: ____-____-____

Current Street Address: _____ Date of Birth: ____/____/____

_____ Current Location: _____

City State ZIP Code

Current Telephone Number: _____ Nursing Facility: _____

SECTION I

PASRR/MI/Level I Screen
(See back of form for definitions)

1. Has a Major Mental Illness Diagnosis as on the back of this form? ☐Yes ☐No
2. Has a history of mental illness in the last 2 years? ☐Yes ☐No
3. Presents with symptoms of major mental illness (excluding primary dementia, substantiated by a neurological exam)? ☐Yes ☐No
4. Has been prescribed or routinely taken antipsychotic or antidepressant medication during the past 2 years? ☐Yes ☐No

List medications and diagnosis/es here:

Psychoactive Medications

_____

_____

_____

_____

PASRR/MR-DD/Level I Screen
(See back of form for definitions)

1. MR-DD diagnosis. ☐Yes ☐No
2. Any history of mental retardation or developmental disability in the individual's past? ☐Yes ☐No
3. Presenting evidence of cognitive or behavioral impairment (before the age of 22) that may indicate that the individual has a developmental disability. ☐Yes ☐No
4. Referral by an agency that provides services to persons with mental retardation or developmental disabilities. ☐Yes ☐No

Diagnosis/es:

_____

_____

_____

_____

Note: If all responses to SECTION I are NO, skip to SECTION III.

SECTION II

Individual Determinations - You must contact State Utilization Review Contractor and obtain clearance.

The individual meets:	Date Authorized by URC
A. Convalescent Criteria	____/____/____
B. Severity of Illness Criteria	____/____/____
C. Terminal Illness Criteria	____/____/____

Confirmation Number provided by State URC: (if applicable)

_____

Comments:

SECTION III

To The Client/Legal Guardian: As a result of one or more "YES" responses on this screen, a more complete assessment may be necessary. This may result in a delay in the processing of your request for a nursing facility placement.

Legal Guardian: ☐ Yes Date of duration ____/____/____ (If yes, please list the name and address below.)

Name: _____

Address: _____

Client / Legal Guardian has received a copy of this form: ☐ Yes ☐ No

To the Preparer of this form: By Federal Law, your signature is verification that a copy has been given to the client.

Printed Name of Preparer: _____ Agency: _____ Date: ____/____/____

Signature of Preparer: _____ Telephone Number: _____

Note: Any "YES" response on this Level I Screen requires review by the Statewide Utilization Review Contractor.

SECTION I

Level I PASRR Screen: Both MI and MR-DD screens are completed if a client is accessing a nursing facility; do not complete for a Continued Stay review or HCBS EBD. All portions must be completed and a signature is required. If the determination by State URC differs from the responses submitted, instructions will be given to indicate the changes. Note that if there are any yes responses, a copy must be provided to the client and to the legal guardian if applicable, and that the required signature verifies that this has been done.

Note that the name and address of the client and legal guardian is required if there are any yes responses; by federal law the legal guardian and client must be notified, in writing, the findings of a Level I failure. Legal guardian definition: Court appointed including medical decision-making, not Power of Attorney (POA).

Level I / MI Instructions

1. Diagnosis of Mental Illness defined as: a diagnosis of a major mental disorder (as defined in the DSM-IV R) limited to **schizophrenia, paranoia, major affective including bipolar, major depression, dysthymia, cyclothymia or schizoaffective disorder or psychosis nos**.
2. Recent (2 year) history of mental illness and includes inpatient psychiatric hospitalization, mental health interventions or symptoms possibly related to mental illness.
3. Presenting evidence of mental illness: patient demonstrates symptomatology and/or behaviors characteristic of mental illness.
4. Use of psychotropic medications without an appropriate psychiatric diagnosis will require a yes response. List all psychotropic medications with corresponding diagnoses.

Any person who has a primary diagnosis of dementia that is based on a neurological examination is exempt from the PASRR process. This dementia exclusion **DOES NOT** apply to individuals with a diagnosis of mental retardation or major mental illness.

Level I / MR-DD

Developmental disability means:

A disability that is manifested before the person reaches twenty-two years of age, which constitutes a substantial handicap to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation.

SECTION II

Individual determinations must be authorized by Statewide Utilization Review Contractor.

A. Convalescent Care Criteria refers to discharge from hospital to NF for a prescribed stay of 60 days or less for rehab/convalescence for a medical or surgical condition that required hospitalization.
B. Severity of Illness Criteria refers to a comatose, vent-dependent, vegetative state.
C. Terminal Illness Criteria refers to physician documentation of life expectancy of less than 6 months.

SECTION III

If the client fails or client requests a copy, the Level I, the client or legal guardian must receive a copy of this form by the referral source (signature verifies that this is done). Name and address must be provided so that a copy can be mailed to them. The above procedures are a requirement per federal regulations. The original copy is sent to the nursing facility. Copies as needed for client, guardian and Statewide Utilization Review Contractor.